	CSB-1108

SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: Person Centered Planning
	Subject: High Risk Admits

PURPOSE: This process is for members who need personal assistance services immediately for the purpose of maintaining their health and safety.

PROCEDURE: Community First Choice (CFC/PAS) agency receives a referral where implementation of services is essential to:

- Prevent institutionalization;
- Facilitate discharge from an institution; or
- Resolve a hazardous home situation that places the member at high risk.

1. The CFC/PAS provider agency sets up an in-home visit with the member/Personal Representative (PR) to develop a temporary CFC/PAS Service Plan. The Plan Facilitator does not need to be present at the visit.

2. The member operates on the temporary CFC/PAS Service Plan until Mountain Pacific Quality Health (MPQH) completes the service authorization documents-a Pre-screen and/or overview and profile. MPQH documentation will include information on the member's provider agency and Plan Facilitator. The MPQH authorization documentation will be faxed to both the provider agency and Plan Facilitator.

3. Once the agency receives the MPQH authorization documentation the provider agency must determine if the member has a Case Manager Plan Facilitator or whether the provider agency is the Plan Facilitator.

    a. If the provider agency is the Plan Facilitator; the agency has 10 working days to schedule the Person Centered Planning (PCP) visit in the member's home. The agency

Plan Facilitator must attend the visit and complete the PCP form (SLTC 200).

b. If the case manager is the Plan Facilitator the provider agency must contact the case manager, notify him/her of the high risk referral, and fax the case manager the temporary CFC/PAS Service Plan. The Case Manager Plan Facilitator has 10 working days upon receiving this notification to complete the CFC/PAS PCP form.

c. The provider agency and Plan Facilitator have two options for completing the CFC/PAS PCP process. The Case Manager Plan Facilitator should contact the member to discuss the options and obtain the member's preference.

Note: The provider agency and Plan Facilitator should document the member's preference for the option that is selected prior to implementing that option.

i. Option 1: The member, provider and Case Manager Plan Facilitator have the option of conducting a coordinated PCP visit within 10 working days of receiving the MPQH documentation to complete the PCP form and update the CFC/PAS Service Plan accordingly.

ii. Option 2: The member, provider and Case Manager Plan Facilitator have the option of coordinating the CFC/PAS PCP process with the member over the phone. The Case Manager Plan Facilitator must complete the PCP form over the phone with the member within 10 working days of receiving the MPQH documentation. The Case Manager Plan Facilitator must obtain the provider agency and member's signature. The PCP form must have the required signatures within 30 days of the case manager receiving the MPQH documentation.

A coordinated meeting must occur within six months of the member beginning CFC/PAS services. This can be done at the member's next case management visit.